the weakening of the uterine wall and the frequency of abortion afterward. He had operated in 3 such cases; 2 going to term, and the third later on had aborted. Where the tumors were such that operation was indicated, the patient generally suffered from considerable pain. The majority of cases which went to term ended in spontaneous labor, but very often there were complications in very severe pain, inertia of the uterus, abnormal presentations and sometimes rupture of the uterus. Where a fibroid is in Douglas's pouch, it can sometimes be pushed above the brim to permit delivery. Where labor is obstructed by fibroids Cesarean section is indicated. If the tumor is so situated that labor can readily go on, the tumor may be removed at some time after labor or if the fibroids were extensive and if there was possible infection, hysterectomy should be done. Craniotomy should not be performed, and nothing could be worse than pulling the head of the child past an obstructing fibroid tumor with forceps. Postpartum hemorrhage (both primary and secondary) is often seen after labor in cases complicated by fibroid, and septic infection is not infrequent. If there was severe pressure or injury during labor the tumor might undergo degeneration, and septic infection develop. During a forceps delivery the tumor might be injured and infection develop later. After a pregnancy fibroid tumors sometimes shrink to a very extraordinary degree.

GYNECOLOGY

UNDER THE CHARGE OF

JOHN G. CLARK, M.D.,
PROFESSOR OF GYNECOLOGY IN THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA,
AND
FRANK B. BLOCK, M.D.,
INSTRUCTOR IN GYNECOLOGY, MEDICAL SCHOOL, UNIVERSITY
OF PENNSYLVANIA, PHILADELPHIA.

Postperitoneal Tumors.—In reporting a case of postperitoneal cystoma, GRAVES (*Surg. Clinics of North America*, June, 1921, p. 607) discusses the histogenesis of postperitoneal tumors in general. They appear in a great variety of forms including fibroma, fibrosarcoma, lipoma, simple serous cystoma, multilocular serous cystadenoma, teratoma, dermoid cystoma, etc. One may readily imagine that such tumors as the fibromata and lipomata have their origin in the subperitoneal cellular tissue in a manner entirely analogous to that which they exhibit in any other part of the body. The unusually large size that they may attain postperitoneally is doubtless due to the slight tissue resistance that they encounter during their growth. One may also imagine that some of the simple serous cysts may arise from isolated rests of the Wolffian ducts. The histogenesis of certain of these growths is, however, not so easily explained. Especially is this true of the dermoids and teratomata. These tumors, whether they originate in the ovaries or postperitoneally, are unquestionably ovigenous. Their development in the postperitoneal cellular tissue has been usually attributed to misplaced blastomeres that, after the original segmentation, have wandered away from their normal place of assembly in the genital gland and have become isolated at some point in the postperitoneal space. The acceptance of this explanation implies a belief in the germ-plasm theory of Weissmann, which asserts that the germ-cells (ova and spermatozoa) are entirely independent in their relation to the body or somatic cells, both in origin and growth. Recent studies in the embryological development of the germinal epithelium covering the ovary have done much to disprove this theory. Thus it has been shown that the genital gland originally develops from the germinal epithelium, which is itself a local modification of the peritoneum. The growth in size of the genital gland is due to an invasion downward of the germinal epithelium, and it has been shown that all the cellular elements of the ovary with the exception of a fine connective-tissue framework are derived from the down-growing germinal epithelium. These cellular structures include the stroma, interstitial cells, the remains of the rete ovarii, and cords of Pflueger, the granulosa layer of the Graafian follicles and finally the ova themselves. It may be seen, therefore, that the ovarian dermoids and teratomata, being ovigenous, are derived in the last analysis from the germinal epithelium. It has also been conclusively proved that the serous cystadenomata are derived directly from the germinal epithelial layer that invests the ovary. Bearing these facts in mind, Graves argues that if the embryonic peritoneum has the power of a local differentiation into the germinal epithelium, which in turn may produce germ-cells, it is entirely conceivable that this power of differentiation may abnormally appear in parts of the peritoneum other than in that portion which is eventually destined to become a genital gland. In this way cells may be created in different areas of the subperitoneal space exactly similar to those in the ovary which have the power of becoming dermoids or teratomata.

Construction of Artificial Vagina.—The technic which GRAVES (*Surg. Clinics of North America*, 1921, p. 611) employs in the construction of an artificial vagina begins with a transverse incision, about two inches in length, which is made across the space usually occupied by the introitus. With blunt dissection a plane of cleavage is sought beginning just above the commissure of the levator ani muscles. It will be found that the tissues may be separated with comparative ease, but some bleeding is encountered, so that it is necessary to proceed cautiously with the separation. In this way an opening is made which corresponds in its proportions to a normal vagina. It is important not to enter the abdominal cavity. Several catgut sutures with long ends are placed in the vault of the new opening and the ends tucked into the pouch for later use, as will be described. The second part of the operation is to line the opening thus formed with skin turned in from the surrounding parts, which may be best accomplished in the following manner: The labia minora are first partially amputated, the incisions beginning near the clitoris and continued downward toward the artificial opening, but leaving sufficient pedicle to allow competent circulation. The skin layers of the partially amputated labia are then separated so that they